Minutes

DCF Learning Center Conference Room, Topeka KS
September 25, 2014 10:00am – 12:00pm

Those attending in person:
Kelley Melton, Keith Dirks, David Rossi, Jennifer Murff, Carrie Kimes, Lora Key, Larry Martin, Mike Larkin, Jerry Delashaw, Doug Klise, Bryan Swan, Kelly Burns, Jonalan Smith, James Bart, Liane Larson

Those attending by telephone:
Frank Clepper, Elizabeth Maxwell, Sandra Dixon, Scott Hines, Allen Schmidt, Jeremy Witt, Jacque Clifton, Lisa Todd, Greg Hennen, Jennie Henault

Review of last meeting minutes:
Shirley Norris, KDHE
The Health Homes representatives were unable to attend this meeting due to other meetings this morning. I will try and have them attend the meeting that we will be having in December.

Guest Speaker:
Kelley Melton, KDHE
Shirley stated Kelley had some slides for everyone that we will send out electronically so that everyone including the individuals on the phone will receive them.

Kelley Melton: We have our three different MCO's that you are familiar with and each of them has contracted with a PBM which is a Pharmacy Benefits Manager. Amerigroup works with Alcon, Sunflower with US Script, and United Healthcare with OptumRX. Those are the claims processors that the pharmacies work with directly to get their claims processed and paid.

Some of the big features for the KanCare pharmacy benefit first are our required prior authorization process. We do require that our MCO's work through the State to be able to require prior authorization for a drug. They do have the ability to do things like quantity limits, gender limits, age limits. But to require clinical prior authorization for a drug, they must work with the State, and we present that joint information to our Drug Utilization Review Board which is made up of Kansas pharmacists and physicians.

The second thing is our Preferred Drug List -- we did require that the MCO's follow the State's fee-for-service preferred drug list. We will make updates to that list on a monthly basis, but the MCO's are required to follow those designations as to if a drug is preferred or non-preferred.

We have state statutes that pertain to the pharmacy benefit by which our MCO's are also required abide. For example, they cannot do step therapy in which you have to try one drug first before you are able to try another drug that may be more expensive or have more side effects.

The MCO's are required to follow our mental health statute as well. We are prohibited from putting prior authorization or limitations on mental health medications such as anti-depressants, anti-psychotics, or anti-anxiety drugs. We have taken a broad view of what falls under this statute.

We also have specialty and mail order language in the pharmacy portion of our contracts. For specialty, they are not allowed to require patients to go to a specific specialty pharmacy. Each MCO does have one specialty pharmacy that they work closely with, but any provider that has the ability to provide these drugs is allowed to do so.

For mail order, we did not want our Kansas pharmacies to be at a disadvantage compared to mail order pharmacies. We just asked that if the MCO's wanted to have a mail order program, it should not be required by the MCO or incentivized in any way. For example, mail order should not be allowed to issue a 90-day supply instead of the 30-day supply that we allow at a regular pharmacy.

Reimbursement, we have tried to make sure that it is very fair for our pharmacy provider's in KanCare. Also, medication therapy management we are excited about. Kansas is one of the first states that has tried to get it off of the ground.

Mike Larkin: On the specialty pharmacy, you said that all three PBM's use one specialty pharmacy?

Kelley: Each PBM is contracted with one. With the specialty pharmacy language, we wanted to prevent the MCO's from being able to say this is a specialty drug and you must go to X pharmacy to get it. That language in the contract really keeps them from being able to do that. There are some drugs that will be a specialty drug, regardless that will not be available at local pharmacies just by the nature of how the manufacturer has set them up for distribution. In those cases, we do see United patients going to OptumRX for example. There may be other options, but for the patients, they sometimes feel it is just easier to use the specialty pharmacy contracted with their MCO. .

Mike: So there are three primary specialty pharmacies that are used and they are the pharmacies that belong to the PBM's?

Kelley: In United's case OptumRX is their primary specialty pharmacy but if a patient wants to go to a different pharmacy they are able to do so.

Mike: How would a patient know that they would have that choice?

Kelley: We have allowed them to message it as such on the prior authorization forms.

Mike: Do you have any specialty pharmacies in Kansas that you prefer?

Jonalan Smith: Both Amerigroup and Sunflower use CVS Caremark. Specialty pharmacies are primarily used around limited distribution drugs. They are usually for drugs that you would never have heard of that are used for rare disease states that are extremely expensive and the manufacturer only distributes them to contracted specialty pharmacies. We have six specialty pharmacies in our network because they have to be within the Kansas border. We have made a few exceptions because there are some drugs that are not available in Kansas because of limited distribution.

Mike: How do you identify a specialty drug? Such as, is that based on price?

Kelley: Normally, the manufacturer will determine to route it through as a specialty.

Mike: Other than the manufacturer, are there any other criteria which indicate that this is a specialty drug?

Kelley: We don't have any other criteria. We look at it more from a network and distribution way. We wanted to have it as open as possible to patients so that there would not be interruptions when KanCare happened. The only way that a drug will be considered a specialty drug with KanCare would be when the manufacturer has distributed it that way or if local pharmacies are unwilling to provide the drug.

Jennifer Murff: One of the benefits of contracting with a specialty pharmacy is that specialty drugs tend to be drugs that are for critical disease states. There is a lot of information, and our specialty pharmacies make sure that patients get very individualized counseling by a pharmacist because of the nature of the disease state. These drugs warrant a higher degree of vigilance.

Mike: My ultimate question is what is the definition of a specialty drug? It may be different for US Script, OptumRX, and CVS Caremark.

Jonalan: None of the MCO's have a list, the State has not created one. A couple of examples would be hemophilia factor or growth hormone injections. For local pharmacies to get access to those medications, they have to agree with the wholesaler and the wholesaler has to agree that they can handle those products. But any pharmacy with that agreement can fill the prescription. We have a couple of infusion pharmacies that are independent pharmacies within the state that do have access to those drugs and fill majority of our prescriptions for those types of drugs.

Kelley: Prior to KanCare, test strips were provided through our DME benefit. A pharmacy would have to be signed up as a DME provider and would process test strips as a medical claim. Moving into KanCare, we continued to do it that way. We did run into a significant number of issues because a lot of our big chain pharmacies did not sign-on to be DME providers as well as pharmacy providers. So patients have had to go and determine who the DME providers are within their community and go those pharmacies to get their test strips.

On October 1st, each MCO will be able to choose a preferred test strip brand and those will be able to be run as a pharmacy claim. These will go through like any other drug claim. This will cover test strips, test meters, and ancillary supplies such as syringes. The non-preferred DME products will not require a prior authorization; they will just have to be run as a DME claim from a DME provider. We are messaging patients, prescribers, and pharmacies information about this change.

Medication therapy management is a big push throughout the pharmacy community nationally to get pharmacies more involved in patient care. Basically on a day-to-day level, pharmacists will notice drug interactions, therapeutic duplication, or things like that and make interventions.

Also, we want pharmacists to start doing annual reviews of their patient's medications. Basically, what we want is for a pharmacist to sit down with a patient, go over their medications, and touch base with their physicians if they need too. Also, have them bring in what the patient is taking at home. To go through the patients medications to determine such things as side effects which may be medication related that they do not realize, are they taking the medication like they are supposed to, and are there any that at this point are unnecessary?

Each of our MCO's has contracted with an MTM vendor. Amerigroup has contracted with Outcomes. United and Sunflower have contracted with Mirixa. The requirements that we laid out for our MCO's for identifying patients is any patient that has at least two disease process states and is on five or more medications can qualify for MTM.

The MCO's are allowed to drive focus one way or the other such as lets identify all of our patients who are diabetic, or all of our patients that have high cholesterol, lets identify patients that are on two or more drugs that are in the same class, etc. The MCO's have been doing this since 2013. Once the pharmacy receives the cases it is up to the pharmacy to outreach to the patient. The MTM members have been reaching out to the patients as well to let patients know that they are eligible for this service. In the slides I have included contact information for pharmacies to go to sign-up for MTM if they have not already done so.

Lora Key: Would you please clarify that for me again. Who identifies the patients, the MCO's?

Jennifer: It is based on the MCO claim data. That data is provided to our vendor and the vendor uses that data to determine patients that meet the criteria and push those cases out to the pharmacies.

Lora: Then the pharmacies now contract with these MTM's?

Jennifer: Then Mirixa will work with the pharmacy to get them contracted since they use their community pharmacies saying they have a case for them.

Lora: What benefit is that to the pharmacy?

Jennifer: The pharmacy then bills for those services.

Kelley: Even if the pharmacy is already contracted with the MCO themselves, they need to be contracted with the MTM vendor to perform these services and bill for them. We believe beyond the financial benefit to the pharmacy when a customer comes in receives these services and has face time with a pharmacist this builds customer loyalty. Also, improves health outcomes because the patient feels they have a pharmacist that they can speak with to ask questions.

Lora: What happens if that pharmacy does not contract for the MTM services?

Kelley: The cases will be pushed automatically to the pharmacy in which the patient fills most of their prescriptions. If that pharmacy is either not contracted or does not work the case after a certain amount of time those will be sent to secondary pharmacies. It may be sent to another pharmacy that the patient uses giving them the opportunity to work the case.

In MTM we really do need greater pharmacy participation. I and our MCO's directors are working with the Pharmacist's Association to resolve some of those barriers. In your local communities this may be something that your providers may not aware of. You may be able to let them know that this is an opportunity.

Reimbursement has been one of the hot topics for pharmacies from the beginning of KanCare. One of the things that has really come up is MAC pricing. The first part of pharmacy pricing is the dispensing fee and that has not changed. The dispensing fee for fee-for-service is $3.40 and we require our MCO's to charge the same as fee-for-service.

In addition to the dispensing fee, a pharmacy will get paid for their drug cost when they dispense a drug. There are two different methods to pay for their drug cost. The first method is called contract pricing and this is what will get used for brand name drugs or generics that do not have a MAC price. It is based on different pricing methodologies in the pharmacy world. There are two that are primarily used and they are AWP which stands for average wholesale price and WAC which stands for wholesale acquisition cost. They are just pricing benchmarks in the pharmacy world to try to set standardized prices. The State used WAC for fee-for-service. If it is a name brand drug, we will pay WAC plus 4.6%. If it is a generic that does not have a MAC price, we pay WAC minus 8.6%. The MCO's are using the AWP formulas for their contract pricing but they are the equivalent of our WAC rates.

Mike: You say MAC is just used for pay-per-service fees?

Kelley: Correct. Contract pricing I am not sure that we have had many issues with. The big piece that is variable is MAC pricing. MAC pricing applies to generic drugs and what we try and do is have rates that are competitive with market trends. They are highly variable because they fluctuate due to supply and demand and when new generics come out. We cover so many different drugs that it would be impossible to keep an up-to-date MAC list so we do allow the MCO's to manage that part of their pharmacy reimbursement. But, they are required to be comparable to what the States MAC rates are.

Contractually all MCO's are required to have an appeals process so if a pharmacy does get underpaid on a claim they can appeal that price and ask the PBM to consider making an adjustment. Also, one thing that is nice for Kansas pharmacies is that our KanCare companies do have MAC lists that are specific to KanCare claims.

Larry Martin: I am just 'carrying the mail' for this example. It's from a local pharmacist that has been in business for forty years. I have 4 ¾ pages of predominantly underpayments. I brought this issue up last year. He had a discussion with about every PBM, and one of the PBM's he asked directly; "Where can I buy it for that price?" The PBM's answer was; "I have no idea." It is not just Medicaid, it is also Medicare, and all of them. He has appealed these so many times and he no longer does because he has never had an appeal approved. The process would work well, but the execution is not there. The MAC list is not dynamic enough to reflect the upward trend in wholesale drug prices. Here is one guy that will be out of business in a few years because you cannot afford to lose sixty dollars on one prescription refill and have 4 ½ pages of that type of thing and stay in business.

Mike: I just want to echo what Larry just said. I receive calls all of the time with basically the same type of scenario that he just described.

Kelley: Our PBM's do have Kansas KanCare specific MAC lists. We do try and have competitive rates. They will analyze how comparable they are to the State's rates. When MAC rates are adjusted they should be retroactive and all the numbers that we show is that pharmacy reimbursement is stable if not more stable than it used to be with the old format of HealthWave plus fee-for-service.

Larry: Again, I am just 'carrying the mail'. He is saying that is not true, because previously when the State ran Medicaid, he would call in they would adjust it to his cost.

Kelley: Correct and that is on the next slide. Something worth mentioning is that previously 60% of our patients were under HealthWave. Under the terms of the conditions of the HealthWave contract, they were allowed to set their own dispensing fee. There was a MAC list which basically did not have any constraints on it. So now that we have moved all of our managed care patients to this new program where the new reimbursement terms are different, we are seeing data showing that the pharmacies are actually coming out slightly ahead.

This slide here is where we get into some of the hurdles that the pharmacies run into. The first thing is that pharmacies are expected to purchase competitively. Where we see most of our MAC issues is with independent pharmacies. So if you have a pharmacy that is not participating in some type of buy-in group or group purchasing arrangement, they are not availing themselves to the best possible prices out there. Our MAC rates are global, so if we set a MAC rate, that is the rate that we are paying every single pharmacy. Say we have an independent pharmacy that is able to get a drug at $.50 a tablet and everyone else is able to get it for $.25. If we set the MAC rate to $.55 to cover the higher cost, we are over paying ninety-five percent of our network by $.30 a tablet. So it is upon the pharmacies to purchase competitively and avail themselves to all possible avenues out there to maximize their profit. From the States perspective, we want to make sure we are paying claims fairly, adequately, and the reimbursements are reasonable. But the pharmacies need to meet us halfway.

Previously, the MAC appeal process was really simple. We had a pharmacy team at HP who could take that call. If it was an urgent issue, we could adjust a MAC rate that day. Everyone knows that with KanCare, there are some extra administrative steps you have to work through. But, we don't have the route that we used to have under fee-for-service to get those MAC rates adjusted. Unfortunately, that is one of the drawbacks, and contractually we have tried to set-up a framework for this process to exist under KanCare.

Those pharmacies that are contracted through a PSAO or a buying group; those are the entities that have contracted with the PBM for them. That is who will need to appeal on their behalf. For some pharmacies, this is frustrating because depending on the terms of their contract with their PSAO, they are sometimes not privy to what appeals have been filed. Some PSAO's have been great about automatically sending in an appeal on every claim that is underwater. Some pharmacies have told me that they are not able to get their PSAO to take any kind of action on it. So we have looked at if there is a possibility of doing something differently there. But, legally our PBM's are in a difficult spot because they are not directly contracted with that pharmacy.

This is a challenge for the pharmacy industry as a whole. We feel that we have tried to get it as right as we possibly can with also working within the restraints of trying to be good stewards of state resources. We understand that there is no way that we are able to pay every providers claim up front to meet every providers cost. Logistically the way prices fluctuate that would be difficult and we would run the risk of overpaying a lot of providers. We have tried to come up with the framework that makes it fair and reasonable.

Lora: What does PSAO stands for?

Kelley: A PSAO is a Pharmacy Services Administrative Organization. Depending on the terms between a pharmacy and their PSAO, the PSAO may do contracting for them or be a buying group. A PSAO will try and work with independent pharmacies to negotiate contracts and reimbursements.

Shirley: How difficult is it for an independent pharmacy to contract with a PSAO or join a buying group?

Mike: I believe unless they have a previous contract directly with a wholesaler, it should be fairly easy.

Jonalan: I can tell you in our network almost all independent pharmacies are contracted with us through some type of buying group. There are a few exceptions because pharmacy owners may have made business decisions which lock them into a contract with the wholesaler for a long period of time.

Mike: If someone has a contract with Medicaid through a PSAO like CVS Caremark for example. They may have multiple providers or contracts with payers. They can talk to them directly if they had a contract with Sprint for example but they won't talk directly with them about a contract with KanCare. For example, a pharmacy may have multiple contracts with CVS Caremark; one is paid by Sprint and one is paid by the State of Kansas. They will talk to them individually on the other plans, but they will not on KanCare?

Jonalan: They could, but all have chosen not to because the rates are better in Kansas than they are in other markets. So it is better for them not to because the state rate is better than the national average.

Mike: The state rate for reimbursement or dispensing fee?

Jonalan: Both.

Mike: If they contract with a PSAO they won't talk to them. But, they will on the other contracts.

Kelley: Are you saying the CVS Caremark will talk to the pharmacy directly on their commercial contracts and the pharmacies are able to appeal their MAC rates?

Mike: That is my understanding.

Kelley: That was a chief complain under HealthWave that they would file appeals and because we didn't have anything contractually.

Mike: Let me double check that, I do not want to say this is absolute. I know I that some of our members have contacted CVS Caremark on individual claims and they have talked to them. But, they won't if they call on a KanCare contract.

Jennifer: Speaking for Optum I can say that their policy is that MAC appeals have to be submitted by the contracted agent. So if an independent pharmacy is contracted with Optum through a PSAO, then the PSAO has to be the entity that submits it.

Kelley: This is not to say that the PSAO will not communicate with the pharmacy about claims issues. Per contractual reimbursement terms and how it is outlined legally, pharmacies have to work with the PSAO.

Mike: You are saying that the PBM will speak to pharmacies about everything except for the reimbursement issues?

Kelley: I cannot say they will talk to them about anything else because I do not know what the legal language is, but I do know that communication-wise on getting the claims processed and troubleshooting, it is completely an open door.

We understand it is not a perfect system and MAC pricing is an issue everywhere and it may be something that CMS looks at changing. They have asked some states to move to a different type of reimbursement methodology where the pharmacies get a much higher dispensing fee but their rates are right at the drug cost. We have tried to get it as close to being fair to everyone.

Jonalan: If you don't submit a price inquiry, the price isn't going to get adjusted. It could, if someone else files the inquiry, but it is something that has to be done. As for overturn rates, we have to contractually report that information to the State on a monthly basis. As far as how many inquiries we have received, how many are overturned, and how many are specifically related to MAC pricing. Just last month, we did a MAC pricing adjustment and we raised 139 MAC prices.

Kelley: That is something else that I will mention, this has not been a static process. We launched this in 2013 and we are looking for ways to continue to improve this. Even just in the last few months we have found improvements that need to be made. We at the State have been looking at our own MAC rates to get them updated.

We have been looking at other states that do have acquisition cost based pricing to make sure we are meeting what the average provider cost is. If you know of providers that have just given up on the appeals process because they filed appeals at the beginning of 2013 and the appeals were not being overturned, encourage them to try again. We have looked again at the process, and we have clarified for the MCO's what we mean when we say comparable to the State's prices.

Mike: When you do make a MAC adjustment, do you do that across the board based on the NDC or do you do that individually by request?

Jonalan: The ones that I mentioned that we raised last month were a combination; they are always across the board. It is for all pharmacies, all drugs for that class, and all manufacturers. We do some on inquiry requests which the more inquiries we receive the more pressing it gets on the list.

When we identified the 139 that we increased we had not received 139 inquiries. We were looking at US Script which has a national MAC list. What we did was take the state MAC list and compared it to US Script's national MAC list and looked at any that we were lower than the national average.

Mike: Do you do that retrospectively?

Jonalan: That depends, if we received an inquiry on July 1st but we do not get it adjusted until July 21st then we will adjust it retrospectively.

Jennifer: Keep in mind that in the MAC appeal process there is a 30 day time limit. So if the claim was filed on July 1st and that was when they lost the money then they have to file that claim with Optum within 30 days. Then there is a 30 day turn-around time which in our stats we have about a 5 day average turn-around time. It is retrospective back to the date of the appeal and that is reflected in what we publish monthly. If there is based on inquiries clearly a drug that has to be addressed because we are getting so many MAC appeals on that then it may be published more frequently. All of those drugs that have MAC pricing changes and the date of the change are identified.

Mike: Do you go back and reimbursement based on the adjustments?

Jennifer: Yes, across the board.

Jonalan: We don't have the capability to determine the specific MAC reimbursement for each pharmacy. The other thing that I just wanted to highlight real quick that Kelley didn't mention but that the State put in the contract as a requirement is for each of us to have a MAC lookup tool. We all have this tool where a pharmacy can look up a MAC price and see when a price was adjusted. If it is a retroactive adjustment it will show you how far it goes back so you can rebill a claim.

Jennifer: Those are posted on the KanCare website as well as on our individual website.

Mike: The other question I had for you Kelley about dispensing fees and other states.

Kelley: What some other states are doing is an acquisition cost based reimbursement model. In Kansas we pay you the $3.40 dispensing fee plus your drug cost. They will survey their pharmacies once a month, they will use an actuary for most states it has been Myers and Stauffer. When they survey their pharmacies they ask what did you actually pay for this drug, and that is the rate that they will pay them. But to compensate for that, they have had to do dispensing fee surveys to see what is your real cost for dispensing a drug. So the dispensing fees end up being anywhere from $10 to $12. Idaho has it set up for their smaller rural pharmacies that they will pay $15 dispensing fee for each claim.

That has been some states and CMS solution to the MAC pricing issue. We will try and pay you more fairly for the drug but we will make sure your dispensing fee more accurately reflects the cost of dispensing the drug. This is becoming more popular.

Mike: I think there would be a lot of positive feedback for something like that.

Kelley: CMS may later require states to move to that on a fee-for-service basis. How that would play out for managed care I could not say. The other thing that CMS is trying and the State supports is that they have developed a national survey. They have surveyed pharmacies nationally to see what their average cost for drugs are. What they expected to see is a lot of regional variation but, that is not what they saw. It was average across the nation.

They have a methodology called the NADAC which is the National Average Drug Acquisition Cost. There are now two states, Alaska and Delaware, that instead of doing their own they are just using the national benchmark plus the $10 to $12 dispensing fee.

Mike: Is that only for fee-for-service?

Kelley: Right now, Delaware does not have any managed care but they are moving to a managed care expansion. Alaska has no managed care as well. So, most of the states that are doing it either don't have any managed care at all or have not made that model applicable to their managed care.

Lisa: Larry if you would find out the details for the pharmacy that is having these issues, I would be happy to reach out and see what we need to do solve his issue.

Shirley: Larry, please send us your list electronically so we can send it out to all of the plans. So everyone can view that. We also have other pharmacies that have generalized complained about the MAC pricing, is that correct?

Larry: Yes.

Shirley: I believe that it is helpful for the plans to know who is having difficulty and they can go out and try and establish a better relationship. This is what we really want.

Kelley: Is there anything thoughts or questions anyone has about this presentation?

Mike: I have a compliment on the test strips moving it to the pharmacies is a good move.

Kelley: Patients may be confused on what they can and cannot get. Feel free to reach out to the resources of the MCO's and myself as well.

Shirley: For everyone on the phone, I will send this slide deck to you so you have all of this information. Pharmacy affects all of our members in one way or another. Some people do not deal with these issues on a daily basis, but it has been informative and interesting.

MCO Updates:

Shirley: I am going to ask the different MCSO's to give a brief update on their most recent initiatives and issues.

David Rossi*, UHC*: We have a large contingent coming up for their open enrollment, so we are preparing for that. We have educational materials and are going out in the communities to educate about the different value added features of KanCare that are available. When they sign-up, we help them with the knowledge of the resources both electronically and phone numbers which will help our customers.

We are preparing for Health Homes for Chronic in 2015. Still trying to talk with providers, we have individuals going to conferences to help with talking with providers and educate them on Health Homes with the intention that we will be going live in 2015. We update the State on a weekly basis on our Health Homes implementation. The providers that are already involved in Health Homes are giving us feedback that this is a good program to rollout.

Carrie Kimes, *UHC*: From a provider perspective, we are shifting from a lot of the issues we had with KanCare the first year and moving to a more standard operating procedure from seeing what we call just normal provider issues of one or two issues. We have been focused over the last year with getting all of the global issues resolved and working with providers on a higher level and now we are working with providers on individual items. For providers, if you feel that you have things hanging for United, please reach out to myself, David, or your provider advocate, and we will schedule some time to look at the data because we have seen that it helps us to fix the issues and start on a clean slate.

Brian Swan, *Sunflower*: We have been heavily engaged over the last several weeks with the Health Homes rollout. We have done about a dozen webinars with a few more planned which seems to be going fairly well.

Doug Klise, is our new Director of Provider Relations. With Doug coming aboard, we are getting ready to do a reorganization of our provider representative territories that we will be publishing to our communities in the coming weeks. We have a new provider representative that will be part of the Wichita area.

We will also be moving forward with some initiatives within our provider relations department based on feedback that we have received from the recent provider satisfaction survey.

We would encourage individuals to sign-up for our e-mail subscription service by going to our home page which is sunflowerhealthplan.com. That is our primary way of communicating with the provider community and getting information out to everyone. One of the bulletins that we released recently is about revamping of some processes within our prior authorization area. For those that would like to view this bulletin it is Sunflower Bulletin 31.

We recently posted our Winter 2014 newsletter. One of the items included in the newsletter will be an upcoming focus within provider relations on HEDIS. HEDIS measures are updated and published annually by NCQA. We will be focusing on some provider education initiatives surrounding the HEDIS measures.

Frank Clepper, Amerigroup: We recently put into production client automation payment and claim communication system. That has cut down turnaround time to around 5 days.

We retired our old system on August 18th. If you have any issues with the new system please contact your provider representative and they will help you. We had a delay in the retirement of PaySpan which was originally scheduled for September 1st but, has been delayed to the earliest November 1st. We are obligated to give providers a 30 day notice before that transition occurs. For those providers who are already enrolled you will automatically rollover and there should not be any interruptions in payments. The only optional feature that you will need to enroll in is the text alerts feature. This feature will send you a text message when a deposit is going to go into your account. There will be several notices going out to providers explaining how to do that.

We are also doing a comprehensive nursing facility rate review. We are reviewing all of the rates that have occurred since implementation and ensuring that we have adjusted appropriately all of those claims.

There was a recent state bulletin sent out to providers about nursing facility rates adjustments due to rate increases provided to the State and that affected the July through September 2014 rate period. All three of the MCO's are working to get these rates corrected in our system and then there will be a recovery process in which we will pay the claims at the correct rate. This is an increase across the board so the provider will not need to take any action. We will do that automatically.

We are working on Health Homes implementation leaning forward to our chronic tier implementation. We anticipate that to occur on January 1, 2015 as well.

We are also in the middle of a road show for long-term care facilities sponsored by the DCF. We would recommend for those that have not participating before please do participate in future road shows. We believe that these have been beneficial from a provider education perspective. Providers please participate in any of Amerigroup's provider forums which are posted on our website.

We are working with the state to prepare documents for the state fair hearings. Explaining how that process works and the timing of that. We are hoping to have this published no later than mid-October for all of the MCO's.

We are involved in preparing for our open enrollment period to make sure that it is a smooth process for both us and the providers as we move into 2015.

Shirley: You have heard about a lot of things that the State has been involved in recently. Open enrollment is coming up, so all of the literature and preparations are taking place. We had employees out at the state fair, meeting and greeting people. From what I have heard, they did hear a lot of positive comments from the public.

Health Homes phase one is going along; phase two chronic conditions are being planned. We are hoping to start enrolling for chronic conditions soon.

Plan updates and bulletins from all three MCO's come through my department. If it is something that is a KDADS area, we send it to KDADS, and they review it. We are getting a lot of that material now because some of the plan manuals are due for revision this fall.

Some of the common complaints that we have been receiving lately have been due to rate changes. We received an angry e-mail that concerned with a recoupment project that had been initiated on the basis of a rate change. Rate changes unfortunately do not originate always with the plans. It can originate with the State, but also can originate with CMS. Such changes often are on a retroactive basis. The plans have to prepare their computer system updates to effect that change. So by the time the system is updated, a provider may have had payment in hand for 5 or 6 months or even longer. They receive a long list of claims that need to be refunded and it makes people upset. I just want to remind everyone that it is not always up to the plans. If you have problems please contact your plan but, if they do not resolve it then contact me. My team will work with the plans.

Jeremy Witt: We have seen a couple of those incidences and I would like to state on behalf of the MCO that they have done a fantastic job on working with us on those rate plan changes. The key to us is that we are required to have a reserve account that absorbs those situations. However, in an ideal world we would prefer to not have to have those contingency plans in place. Under the previous KDOA model

when something like this would occur we worked with a couple of KDOA representatives and worked out a payment plan extending anywhere from a year to eighteen months. Is there any way that we can investigate something along those lines because we are just taking a stab at what our fiscal policy should entail to obtain a reserve account to absorb those types of situations. Is there a way that we can have a policy similar to the previous policy that we had with the KDOA?

Shirley: Yes, Jeremy. I will take that. I will speak with all three of the MCSO's and talk with the state to see if that is a possibility. I know that it is difficult especially for small providers or medium sized providers to do any forecasting on their budget. You have to plan several years in advance and that is difficult to come up with some type of reserve that can take the hit when you do have a recoupment problem.

Mike: Is there any time limit or how far back you can go back on something like that?

Shirley: We would not be going pre-KanCare at this point I don't believe. It would be rare for us to go back beyond a year. But, if it is something that is mandated by CMS, we may not have a choice. If the plan knew that they had a plan processing error, I do not know of a limit but I believe they can go back and request refunds. In a program integrity fraud investigation, they can certainly go back and request funds.

Carrie: As a general rule we cap our look back at a year. It is a year from the date the claim was paid. Not by the date of service. But to Shirley's point where we recently had some retroactive nurse rate changes that went back to April of 2013 which would be out of our year look back period. Since it is a retroactive rate change, those are ones that we do have to consider and go back and recoup those claims when it is outside that year. But, that really is not the norm.

Lora: Once the money is recouped, what is the turn-around time to reprocess those claims and get them paid back?

Carrie: For United, it is a three step process. Step one is we identify the claims that were overpaid. We send a letter to the provider stating that these claims and based on our agreement with providers we hold that for 45 days to give them an opportunity to review, dispute, or appeal anything that we found. If after that 45 day time period you have not disputed it or we have resolved any questions you may have, we go ahead and submit those claims to be recouped. You should not see more than a few days gap between the recoupment and the payment it is just two separate actions.

Kelly Burns: For Sunflower, the process is very similar to United's process. If we identify that we have a rate change that affects a provider in a negative way depending on the amount of the negative balance that it is going to generate, our provider relations team would reach out to the provider and make them aware of the potential recovery. We would give the provider anywhere from 30 to 60 days to either make an agreement with us, or if after that 60 days, there is no dispute or feedback from the provider, we would reprocess those claims.

We try to ensure when we do recoupments after a project, we consolidate those and manage those projects more closely so that all occurs on one remittance. Earlier in the year, we had a project that had a negative impact where providers saw a large negative balance on one remittance. Then receive a

payment back on a second remittance. This caused some customer service complaints and general confusion for providers.

Carrie: To Kelly's point, there is a level of threshold that is very similar to what the State had in place. If the overpayment is under $10 we leave that alone, because from an administrative point it is more costly for us and you to go through with the adjustment.

Frank: Pertaining to a rate change in the long-term care rate schedule, we have been able to get those changes into our system prior to the first effective date if we had gotten those quarterly rate changes usually 30 to 40 days in advance.

For the specific rate change that happened in July through September 2014 time frame because we were already using the October 1st rates we ended up having to delay that so that we could get all of the rate changes into our system by October 15th. We give ourselves 30 to 60 days after that to make all of those adjustments. There is nothing that our provider will have to do for that. For interim rate changes it generally takes us 30 to 40 days to make that change into the provider's configuration. For overpayments we use our refund process that we have in place to get overpayments reconciled.

Larry: I have been informed that the Department of Labor is seriously considering removing the exempt status for homecare workers that are not direct hire but are basically agency employed. Agencies will be required to pay overtime to anyone that works over 40 hours. You cannot discriminate in your charges that you have overtime so this has to be factored into the rates. In the waiver programs that we handle there are two rates $14.92 and $13.08; our average salary is under $10 per hour. The average hour actual reimbursement charge rate for a home care agency in the State of Kansas is about $20 an hour. There is going to be even more pressure now because about 7% or 8% of our total time is overtime. We are going to raise our private rate rates up to about $21 an hour; that still will not cover it. But, it is going to put more on the Medicaid side and I tell this just for information for the MCO's. We only do Medicaid for hours for caregivers. We always do it for quality care but there is not much profit on the Medicaid side. This may become effective January 2015 and I have made Kansas Homecare Association aware of that.

Shirley: I know that KDHE, KDADS, and the MCSO's have been reviewing this and we have had some discussion with the Department of Labor pertaining to what the true definition and who would actually be affected?

Larry: I believe if you pay privately a caregiver it doesn't apply. But, if you're an agency it does.

Shirley: I believe that is what it is leading towards. It could have a huge impact.

Larry: How we manage that internally it that the only individuals that work overtime are those that want too.

I/DD Waiver Implementation Updates:

James Bart, KDADS

Along with the Department of Labor discussions that are occurring there are also discussions of how it relates to taxation. KDADS is involved with discussing this with our federal partners on the final rule; there is not a conclusion at this point.

Another topic within KDADS is home community based services and the cost implications for that. The State has communicated its plan to the setting rule. If you go to KDADS website it lays out the time frame for looking at the possible implications of the settings rule.

Some of the waivers are being renewed and they are under a pretty tight time frame. If you look on the KDADS website you will see what waivers are being reauthorized and need to be communicated with the provider groups.

Comments from the Chair:

Shirley Norris, KDHE

Next meeting I am asking the MCSO's individuals that are here we would like to get some input from your Behavior Health subcontractors because that is something that has been requested by the providers of this group. They would like a report from your Behavioral Health subcontractors maybe similar to what Kelley presented and how they process claims and appeals. I am also hopeful that we will have someone here to do Health Homes.

Again, just a reminder this was a committee that was designed from the Governor's Advisory Council and as providers, you are all representatives of your specialty and also of your community. James' and I would ask that you go back to your community and your fellow providers. Please share the information that you receive and the links that we send to you. This is set up as a forum for you to receive information and we are hoping that you go out in the community and disseminate what you have learned here.

Our next meeting is December 11th from 10am to 12pm at DCF. After that it would be March 18th.

Carrie: Do you want the Behavior Health individuals to be part of the December 11th meeting?

Shirley: Yes, please. I want to thank the pharmacy individuals for coming, very informative. Thank you everyone.